DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435029	A. BUILDING _____ B. WING _____	04/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA ROSEBUD COUNTRY CARE CENTER	300 PARK STREET PO BOX 408 GREGORY, SD 57533

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Addendums noted with an asterisk per 6/3/13 telephone to facility administrator and DON. PE 6/6/13	F 000	All residents will be offered an interest bearing account at admission and at any time they wish to have the facility manage their money. All residents/families (including the seventeen cited) currently having funds locked in the safe at the nursing home were offered interest bearing accounts. One resident opened an interest bearing account. Other residents reduced the amount of funds in their accounts. Individual account envelopes have been discontinued and a petty cash fund established. This fund is kept in the South nurses station in a locked cabinet. Keys to the door and cabinet are kept in the medication room. Each resident with funds less than $50 dollars has an individual ledger sheet to record transactions. All transactions will be witnessed by two staff members.	
	Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/23/13 through 4/24/13. Avera Rosebud Country Care Center was found not in compliance with the following requirements: F159, F221, and F441.			
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of	F 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO | 20 MAY 13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	Continued From page 1 resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on observation, interview, and admission agreement review, the provider failed to appropriately manage personal funds for 17 of 17 sampled residents (6, 7, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, and 24) who had deposited personal funds with the provider. Findings include: 1. Interview on 4/24/13 at 1:40 p.m. with the social service designee (SSD) revealed the provider had envelopes of residents' cash in a locked cabinet in a locked storage room. Observation on 4/24/13 at 1:45 p.m. with the SSD revealed she entered the medication room, got a set of keys, entered the locked storage room, opened the locked cabinet, and removed the	F 159	Quarterly statements for interest bearing accounts will be mailed to the resident/family by the Social Services Designee or her designee. Social Services will audit resident funds on a monthly basis for six months, then quarterly for a year to verify compliance. Results of audits will be reported by the Social Services Designee or her designee to the Performance Improvement Committee and Compliance Committee on a quarterly basis. The next Performance Improvement Committee meeting will be held July 18, 2013 and Compliance Committee will be held August 1, 2013.	5-22-13

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F 159	Continued From page 2 residents' cash envelopes. Review of the envelopes revealed cash amounts for the following residents: *Resident 6 - current and highest balance of $58.00. *Resident 7 - current balance of $36.65 and highest balance of $56.65. *Resident 9 - current balance of $20.00 and highest balance of $70.00. *Resident 11 - current balance of $1.05 and highest balance of $30.00. *Resident 12 - current balance of $8.00 and highest balance of $105.00. *Resident 13 - current balance of $16.00 and highest balance of $50.00. *Resident 14 - current balance of $22.50 and highest balance of $52.36. *Resident 15 - current balance of $30.00 and highest balance of $60.00. *Resident 16 - current balance of $40.00 and highest balance of $60.00. *Resident 17 - current and highest balance of $47.00. *Resident 18 - current balance of $38.00 and highest balance of $58.00. *Resident 19 - current balance of $50.42 and highest balance of $82.50. *Resident 20 - current and highest balance of $3.00. *Resident 21 - current and highest balance of $65.00. *Resident 22 - current and highest balance of $16.00. *Resident 23 - current and highest balance of $39.82. *Resident 24 - current and highest balance of $17.00.	F 159		

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F 159	Continued From page 3 Continued interview at the above time with the SSD revealed: *The nurses had access to the keys where the money was kept. *The cash transactions were recorded on each resident's envelope and on a ledger sheet for each resident. *When residents added cash the amounts were noted by two staff members. *When residents withdrew cash the amounts were noted by two staff members. *The SSD and one other staff member usually audited the envelopes and ledger sheets quarterly. Interview on 4/24/13 at 2:00 p.m. with the financial manager and the SSD confirmed the residents' personal funds were not kept in interest bearing accounts. Review of the provider's undated Nursing Care Facility Admission Agreement revealed: *Residents were allowed to choose to deposit funds into a resident trust fund. *The provider would hold and safeguard resident funds. *The resident trust fund would be maintained by the provider. *Residents acknowledged whether or not they wanted their personal funds held in a resident interest bearing trust account.	F 159		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221		

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F 221	Continued From page 4 This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, and policy review, the provider failed to ensure a device that restricted movement was identified and assessed for one of one sampled resident (2) with the device. Findings include: 1. Random observation on 4/23/13 from 3:00 p.m. until 4:45 p.m. of resident 2 revealed: *She sat in a remote controlled electric recliner in her room. *The recliner was positioned so her legs were elevated, and her head was reclined back. *The recliner remote was not available to the resident. Interview on 4/23/13 at 5:00 p.m. with certified nursing assistant A regarding resident 2 revealed: *The resident would have fallen out if she had the remote, as she could have put the chair up too high. *The remote to her recliner was put behind the chair to prevent the resident access to it. Review of resident 2's 3/23/13 care plan revealed: *Her problems included: -A diagnosis of Alzheimer's disease and depression. -A history of hallucinations and delusions. *She was a high risk for falls. -An intervention was to keep her recliner control placed behind the chair in a container. -That intervention had been in place since	F 221	Restraint was eliminated for Resident #2 on 4-25-13. New employees will receive education regarding restraints during orientation. Certified Nurse Aide trainer will provide education. Inservice for all staff was held on 5-16-13 to review policies and procedures for restraints. Yearly education will be provided to all staff regarding restraints to ensure policy is followed. Director of Nursing or her designee will provide this education. Director of Nursing or designee will conduct monthly safety device* and/or restraint use audits. Audit results will be reported by the Director of Nursing or designee to the Performance Improvement Committee and Compliance Committee on a quarterly basis until Performance Improvement Committee advises to discontinue. PE/5000H/JJ	

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F 221	Continued From page 5 10/29/10. Interview on 4/24/13 at 9:15 a.m. with the director of nursing revealed: *A restraint was anything that restricted a resident's personal movement. *The removal of the remote for resident 2's recliner had been put in place after she had been admitted and had slid out of her chair. *Resident 2 had been a resident for at least a couple of years. *They had not considered the removal of the remote to resident 2's chair a restraint. *She agreed removal of the remote had restricted resident 2's movement. *There was not a policy on restraints, because they had not thought they had any restraints. *An assessment had not been done on resident 2 to evaluate if removing the remote to her chair was restraining her.	F 221	The next Performance Improvement Committee meeting will be held July 18, 2013 and Compliance Committee will be held August 1, 2013.	5-16-13
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 6 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Preceptor: 26180 Based on interview and policy review, the provider failed to ensure sanitary techniques were maintained for two of two general resident use tub areas. Findings include: 1. Interview on 4/24/13 at 8:30 a.m. with certified nursing assistant (CNA) E revealed when cleaning the tubs she would leave the disinfectant on the tub surfaces for three minutes. She stated she had been orientated to that procedure by other CNAs.	F 441	All staff in-service was held on May 15, 2013 to provide education and training regarding protocols for proper use of whirlpool tubs. The Certified Nurse Aide Trainer supervised competency testing for all bathing staff, completed May 20, 2013. Yearly bathing competency under the supervision of the Certified Nurse Trainer will be completed each May for all staff giving baths. New staff will be provided the same training and bathing competency as they are hired. This will be done by the Certified Nurse Trainer or her designee. Instructions for operation of the whirlpool tubs were posted on the wall of each tub room and a copy placed in the bath cabinet.	

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F 441	Continued From page 7 Observation of the label on the Penner Patient Care Whirlpool Disinfectant Cleaner bottle with CNA E at that time revealed it required a ten minute contact time for proper disinfectant. Interview on 4/24/13 at 8:43 a.m. with CNA D revealed when cleaning the tubs she would leave that same disinfectant on the tub surfaces for fifteen to twenty minutes. She stated she had been orientated to that procedure by other CNAs. Interview on 4/24/13 at 9:00 a.m. with CNA C revealed when cleaning the tubs she would leave that same disinfectant on the tub surfaces for ten minutes. She referred to the proper tub disinfection protocols that were posted in the tub areas. Those protocols were not present in the north tub area. She stated she had been orientated to that procedure by other CNAs. Interview on 4/24/13 at 9:10 a.m. with the infection control nurse revealed she did not know the procedure on tub disinfection. She referred the question to the director of nursing (DON). Interview on 4/24/13 at 9:20 a.m. with the DON revealed: *She would have expected the CNAs to follow the manufacturer's directions. *She was not aware of what the manufacturer's directions were. *There was no whirlpool or tub disinfecting procedure. Review of the undated provider's Tub Cleaning Protocol posted in the west bath area revealed the disinfectant contact time was to have been two minutes.	F 441 and Performance on whirlpool cleaning PE/SS/OH/JJ	The Quality Control nurse or designee will audit the training of new staff on a monthly basis. Audits will be completed monthly for three months, then quarterly. Audit results will be reported by the Quality Control Nurse or designee to the Performance Improvement Committee and Compliance Committee on a quarterly basis until Performance Improvement Committee advises to discontinue. The next Performance Improvement Committee meeting will be held July 18, 2013 and Compliance Committee will be held August 1, 2013,	5-16-13

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F 441	Continued From page 8 Review of the March 2006 Penner Manufacturing MasterCare Integrity Bath with Console operating instructions revealed "allow contact time per disinfectant cleaner label." Review of Penner Patient Care Whirlpool Disinfectant Cleaner label revealed "product to surface contact time must be at least ten minutes for proper disinfection."	F 441		

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	435029	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/23/2013**

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AVERA ROSEBUD COUNTRY CARE CENTER	**300 PARK STREET PO BOX 408** **GREGORY, SD 57533**

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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/23/13. Avera Rosebud Country Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 4/23/13 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and measurement, the provider failed to maintain clear door widths of at least 32 inches in two smoke barriers (central core area to the north wing and west wing). Findings include:	K 028		F

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K 028	Continued From page 1 1. Observation and measurement at 10:30 a.m. on 4/23/13 revealed each leaf of the two sets of smoke barrier doors for the central core area to the north wing and the west wing were only 30 inches wide. Those door leafs did not provide the required clear opening width of 32 inches. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028		
K 038 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on document review and interview, the provider failed to install a paved path of exit discharge to the public way at three exits (the middle of the west wing, the end of the west wing, and the exit out of the connecting link for the hospital). Findings include: 1. Review of the previous survey revealed: *The exit in the middle of the west wing basement had a landing that ended approximately 150 feet from the nearest public way. *The exit at the end of the west wing basement had a landing that ended approximately 200 feet from the nearest public way.	K 038		F

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K 038	Continued From page 2 Interview with the environmental services director at 1:35 p.m. on 4/23/13 confirmed that condition. She added they had been clearing a path from those exits to a public way when any snow fell. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 038		

SOUTH DAKOTA DEPARTMENT OF HEALTH

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	10625	A. BUILDING _____ B. WING _____	04/24/2013

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AVERA ROSEBUD COUNTRY CARE CTR	300 PARK STREET, PO BOX 408 GREGORY, SD 57533

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S 000	Initial Comments Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/23/13 through 4/24/13. Avera Rosebud Country Care Center was found not in compliance with the following requirement: S236.	S 000		
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Rule is not met as evidenced by: Surveyor: 32572 Preceptor: 26180 Based on record review, interview, and policy review, the provider failed to ensure three of five sampled staff members (D, F, and G) received a	S 236	Each new healthcare worker will receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment. A two-step TB skin test will be administered as necessary to those who have a lapse longer than 13 months between TB skin tests. A one-step TB skin test will be administered if there is proof of one other test within the previous 12 months. All new hires will receive a Mantoux skin test on their first or second day of employment, with those requiring a second step that will be completed one week after the initial Mantoux test. Employee Health Nurse or designee will be responsible for administering the TB test and making sure established time line is met.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	20MAY13

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10625	A. BUILDING _____ B. WING _____	04/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA ROSEBUD COUNTRY CARE CTR	300 PARK STREET, PO BOX 408 GREGORY, SD 57533

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 236	Continued From Page 1 two-step Mantoux tuberculin (TB) skin test or TB screening within fourteen days of employment. Findings include: 1. Review of staff member D's complete employment record revealed: *The date of hire was 9/19/12. *The TB skin test done was completed twenty-eight days after being hired. 2. Review of staff member F's complete employment record revealed: *The date of hire was 3/22/13. *The TB skin test done was completed twenty-four days after being hired. 3. Review of staff member G's complete employment record revealed: *The date of hire was 11/21/12. *The TB skin test done was completed twenty-one days after being hired. 4. Interview on 4/24/13 at 9:50 a.m. with the director of nursing revealed: *She was unable to determine the employment dates of the above individuals. *The hire date and start of employment date were not the same dates because of the corporate electronic system. Interview on 4/24/13 at 9:55 a.m. with the admissions coordinator revealed the employee hire date was the date all of the initial employment documents were signed. Interview on 4/24/13 at 10:10 a.m. with the director of patient services revealed the date of employment was the same date as the date of hire. Review of the provider's revised July 2012	S 236	TB skin testing will be monitored by the Employee Health Nurse or designee for all new hires on a monthly basis. Audits will begin in May, 2013 and will be completed monthly for two (2) months on every new employee and then quarterly to verify that TB skin testing met the 14 day requirement. The Employee Health Nurse or designee will report the results quarterly to the Performance Improvement Committee and Compliance Committee. The next Performance Improvement Committee meeting will be held July 18, 2013 and Compliance Committee will be held August 1, 2013.	5-16-13

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 236	Continued From Page 2 Employee Health, Employee Annual TB test or TB Assessment policy revealed "Baseline tuberculin skin test (TST) or a current chest X-ray will be required on all new hires within 14 days of employment."	S 236		